ficial. Posterior sclerotomy, on the other hand, can only relieve the space between the choroid and the sclera, leaving the anterior filtration channels unopened.—*Transactions Heidelberg Ophthal. Congress*, 1897.

[The especial liability of the limbus to infiltration, if confirmed by other observations, together with the fact that the whole of this infiltration circle can communicate with and so drain through an opening made into one part of it, through the spaces known as the canal of Schlemm, offers the best explanation yet suggested of the curative power of iridectomy and other allied operations.

The fact that after organization of an exudate drainage would have little influence in removing it will also serve to explain the comparative inefficiency of operative treatment in chronic glaucoma.—J.]

The Mechanism of Eye-movements.—C. WEILAND (Philadelphia) urges that the common assumption of any complete antagonism of one ocular muscle to another, the internus to the externus, the superior to the inferior rectus, and the superior to the inferior oblique, is not correct; that the muscles do not act in pairs, each of a pair tending to rotate the eyeball in opposite directions about the same axis; but that each individual muscle tends to rotate the eyeball about an axis peculiar to itself, and therefore no one muscle can perfectly antagonize another, and no two muscles acting harmoniously can alone direct the two eyes toward a particular point. In all or almost all eye-movements, all of the muscles participate in varying degree. The weakness of one muscle can often be compensated by increased action of others.

Weiland makes some very interesting and instructive calculations regarding the shares which the different muscles take in the causation of certain movements of the eyes, and he urges that the assumed simplicity of the ocular movements is incorrect and misleading. His calculations are based on the determinations of the muscular attachments made by Volkmann.—*Archives of Ophthal.*, 1898, No. 1.

[Weiland's paper, although quite technical, is an important one. The simple working out of the numerical values of the traction exerted by each of the several muscles in causing a certain movement of the eye emphasizes, as nothing else can, the extremely complex nature of the common ocular movements. To some extent it is a *reductio ad absurdum* of the anatomical method of studying eye-movements and their disorders. Anatomical conceptions regarding these movements have value, but it becomes very evident that they must be supplemented by a better understanding of such movements from the side of their physiological relations.—J.]

Operation for Ptosis.—W. H. WILDER (Chicago), for complete paralytic ptosis, employs the following operation: An incision one inch and a half or more in length is placed where the scar will be concealed by the eyebrow. The lower lip of this incision is drawn down and the skin and muscle carefully dissected from the fascia down to the tarsus. Two sutures of fine sterilized catgut or silk, armed at each end with a curved needle, are then passed in the following manner:

The first needle is introduced deep enough into the tarsus to secure a firm hold at a point about at the junction of the outer and middle third and a little distance from its convex edge. It is then drawn through, and with it several gathering stitches are taken in the tarso-orbital fascia, after which the needle is made to pass through the muscle and connective tissue of the upper lip of the wound. The other needle on the same suture follows a parallel course in the same manner, entering the tarsus about three millimetres from the point of entrance of the first, then gathering the fascia into small folds and emerging in the tissue above, thus making a loop by which the lid may be drawn up.

The second suture is passed in the same way, making a loop at the junction of the middle and inner third of the tarsus. The requisite elevation of the lid may be now secured by drawing on the loops and tying the sutures, which are to be buried in the wound.

The lower lip of the wound is now united to the upper with fine sutures. The slight scar that remains after healing is almost entirely hidden when the eyebrows grow again. The buried sutures become encapsulated and give additional strength to the folds of fascia that hold up the lid.—*Annals of Ophthal.*, 1898, No. 1.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

J. SOLIS-COHEN, M.D.,

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Inspection of the Posterior Wall of the Larynx.—Various devices have been employed from time to time in order to expose the posterior wall of the larynx to inspection, the foreshortening of its image in the ordinary method of laryngoscopy often preventing due appreciation of existing lesions.

The latest device is by Dr. Mermod, of Iverdon (*Annales des Maladies de l'Oreille, du Larynx, etc.*, 1898, No. 2). This consists in the use of a second mirror, which is placed within the cavity of the larynx, and which he appropriately calls a laryngendoscope. Its reflecting surface is directed toward the reflecting surface of the ordinary mirror. A small, heart-shaped mirror, movable upon its shank and controlled by a screw, is attached to the extremity of a laryngeal handle of the ordinary curve.

The illumination must be good in these cases, because the image has to be reflected from one mirror upon the other.

Transmission of Diphtheritic and Scarlatinic Sore-throat.—Dr. Francis T. Bond has had his attention called (*British Medical Journal*, 1898, No. 1831), by a very intelligent mistress of a board school in his district, to a practice which obtains, in infant schools especially, and which he thinks is accountable for a good deal of obscure communication of the disease. It is